MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes ( ) No
Requestor's Name and Address Edward Wolski, MD / Wol+Med 2436 IH-35 E. South, Ste. 336 Denton TX 76205	MDR Tracking No.: M4-03-6951-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 47 Continental Casualty Co. c/o Wilson, Grosenheider PO Box 1584 Austin TX 78767	Date of Injury: Employer's Name: Staff Leasing Insurance Carrier's No.: 9000422872

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
5/15/02	9/3/02	97032 x 2 units x 3 days	$3,048.00	$714.00
		97139-PH x 2 units x 3 days		
		99070 x 2 units x 3 days		
		97110 x 2 units x 4 days		
		97530 x 2 units x 4 days		
		95851 x 2 days		
		97799-JA x 2 days		
		99070-Brace		
		99213 x 3 days		
		97012		
		99212		
		E1399		
		97024		
		64999		
			Total:	$714.00

PART III: REQUESTOR'S POSITION SUMMARY

6/18/03: "Our Position: The carrier responded to our initial billing with Payment Exception Code "D-duplicate billing". We have never been paid for our services… We also feel the carrier failed to respond to Rule 133.304…response to request for reconsideration…We…should be reimbursed for our services…"

PART IV: RESPONDENT'S POSITION SUMMARY

6/20/03: "…Statement of Disputed Issues: Provider seeks additional reimbursement for various services provided… DOS 7/1/02 and 7/12/02…paid in full…For the remaining DOS, Carrier denies reimbursement because as a threshold matter, healthcare must cure or relieve the effects of the compensable injury, promote recovery…enhance the ability to work…Provider has not submitted any documentation to show…results…Claimant's treatment has not been objectively measured, fails to demonstrate functional gains, and is not consistent in demonstrating ongoing progress in the recovery process by appropriate re-

evaluation of the treatment. Because there is no objective evidence to support the efficacy for this treatment, Provider is not entitled to reimbursement…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- This dispute was received by MDR on 5/12/03. Respondent submitted copies of EOB's, dated 8/25/02 and 9/5/02. These EOB's explained reimbursement for DOS 7/1/02 and 7/12/02. DOS 7/1/02, CPT 99213 and DOS 7/12/02 for CPT codes 97110 (2 units), 97113 (2 units) and 97530 (2 units) were paid according to MAR, therefore, $292.00 deducted leaves $2,756.00 in dispute.
  The requestor did not respond with an up-dated table indicating any lack of reimbursement for these DOS, Therefore, these DOS are considered paid and will not be reviewed further in this Finding and Decision.

- The only set of EOB's/TWCC-62 (dated 1/7/03), presented by the requestor for the DOS in dispute, were denied with "D-This item was previously submitted and reviewed with notification of decision issued to payor/provider (Duplicate Invoice)." The respondent, in their response, did not supply the 1st or 2nd set of EOB's or additional information about other EOB's that would clarify the denial of "D-duplicate billing" according to rule 133.304 (a-e), therefore the remaining DOS will be reviewed as fee issues only.

- The remaining CPT Codes in dispute are recommended to be reimbursed as follows:
  *97032 x 2 units x 3 days (DOS 5/15/02, 5/16/02, 5/18/02): The submitted notes support treatment rendered. Reimbursement according to MAR, MFG descriptor and MFG/MGR (I)(A)(10)(a), $22.00 ea x 6 units = **$132.00**
  *97139-PH x 2 units x 3 days (DOS 5/15/02, 5/16/02, 5/18/02): Per MFG/GI (III), MFG/ MGR (I) C), DOP and 133.1(a)(8), convincing evidence was not provided by the requestor to substantiate their usual and customary rates therefore reimbursement can not be recommended.
  *99070 x 2 units x 3 days (DOS 5/15/02, 5/16/02, 5/18/02) MAR is DOP. 133.1(a)(8) Convincing evidence was not provided by the requestor according to 133.1 (a)(8) to substantiate their usual and customary rates, therefore reimbursement can not be recommended.
  *97110 x 2 units x 4 days (DOS 5/15/02, 5/16/02, 5/18/02, 8/8/02): Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light of all the Commission requirements for proper documentation. Submitted S.O.A.P. notes do not document the severity of the injury that would require exclusive one-to-one supervision. Reimbursement is not recommended.
  *97530 x 2 units x 4 days (DOS 5/15/02, 5/16/02, 5/18/02, 8/8/02): Therapeutic activities documented per S.O.A.P. notes, therefore according to MFG/MGR (I)(A)(10)(a), reimbursement recommended per MAR in the amount of ($35.00 x 2=$70.00 x 4 days**=) $280.00.**

  *95851 x 2 days (DOS 5/16/02, 5/18/02): Range of motion reports were not received for review

according to MFG Descriptor and MFG-MGR (I)(E)(4) therefore, reimbursement can not be recommended.

*97799-JA x 2 units (DOS 5/22/02): Convincing evidence was not provided by the requestor to substantiate their usual and customary rates according to DOP, MFG/MGR (I)(E)(1) and 133.1(a)(8), therefore reimbursement can not be recommended.

*99213 x 3 (DOS 5/28/02, 8/8/02, 9/3/02): S.O.A.P. notes substantiate services rendered according to MFG Descriptor, MFG/EM IV and VI, therefore reimbursement recommended per MAR, ($48.00 x 3 days=) **$144.00**

*97012 x 1 (DOS 7/15/02): Treatment documented per S.O.A.P. notes, therefore according to MFG/MGR (I)(A)(10)(a), reimbursement recommended per MAR in the amount of **$20.00.**

*99212 x 1 (DOS 7/22/02): S.O.A.P. notes substantiate services rendered according to MFG Descriptor, MFG/EM IV and VI, therefore reimbursement recommended per MAR, **$32.00**.

*99070-BRACE (DOS 5/28/02): The requestor did not provide convincing evidence indicating a brace was presented to the injured worker and/or usual and customary rates charges, therefore reimbursement can not be recommended.

*E1399 (DOS 7/22/02): Per S.O.A.P. notes, reimbursement recommended per Medical Fee Guideline, DME/GR (IX)(c), amount due, **$85.00.**

*97024 (DOS 8/8/02): Treatment documented per S.O.A.P. notes, therefore according to MFG/MGR (I)(A)(10)(a) reimbursement recommended per MAR in the amount of **$21.00**.

*64999 (DOS 8/23/02): Convincing evidence was not provided by the requestor according to 133.1(a)(8) to substantiate their usual and customary rates, therefore reimbursement can not be recommended.

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $714.00___. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Name	4/29/05 Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, 7551 Metro Center Drive, Suite #100, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____